#### Section 4 – FORMS

S	ection 4 – FORMS	1
	Health and Education Passport (HEP)	2
	JV 220 – Application and Order for Authorization to Administer Psychotropic	
	Medication – Juvenile	2
	JV 220A – Opposition to Application for Order for Authorization to Administer	
	Psychotropic Medication – Juvenile	2
	JV225 – Health and Education Questionnaire	
	DHS 4484 – Access ID Problem Form	
	Data Form - Examples of Children Helped Through CMS (Section 4 of PFG)	
	Reporting Form for Performance Measure 5 (Section 3 of PFG)	
	CHDP Referrals	
	CHDP Referral (PM 357)	
	CHDP Referral for SAWS Automated Template	
	CHDP Referral for Welfare Case Data System Counties	8
	PM 160 – Confidential Screening/Billing Report	g
	PM 161 – Confidential Referral/Follow Up Report	11
	PM 160 Sample Forms and Instructions	13
	CHDP Forms and Publications	13

This section provides the links and some examples of the various forms used by the California Departments of Health Services and Social Services by the PHNs for the care of foster children. Please note that some form examples may be outdated and the website should be checked for the most current form.

#### **Health and Education Passport (HEP)**

http://www.hwcws.cahwnet.gov/training/nu\_curr.asp

#### JV 220 – Application and Order for Authorization to Administer Psychotropic Medication – Juvenile

(nurses should access these forms via the child's CWS/CMS case)

http://www.courtinfo.ca.gov/forms/fillable/jv220.pdf

# JV 220A – Opposition to Application for Order for Authorization to Administer Psychotropic Medication – Juvenile

(nurses should access these forms via the child's CWS/CMS case)

http://www.courtinfo.ca.gov/forms/fillable/jv220a.pdf

#### JV225 – Health and Education Questionnaire

(nurses should access these forms via the child's CWS/CMS case)

http://www.courtinfo.ca.gov/forms/fillable/jv225.pdf

#### DHS 4484 – Access ID Problem Form

http://www.dhs.ca.gov/publications/forms/pdf/dhs4484.doc

# Data Form - Examples of Children Helped Through CMS (Section 4 of PFG)

A form used by CMS county programs to evaluate program needs, performance, and trends. The form is submitted with the county's annual budget plan.

http://www.dhs.ca.gov/pcfh/cms/pfg.htm

## **Reporting Form for Performance Measure 5 (Section 3 of PFG)**

A form used by the CMS county programs to provide effective care coordinationt of their children. The form is submitted as part of the county's annual budget plan.

http://www.dhs.ca.gov/pcfh/cms/pfg.htm

#### **CHDP Referrals**

# CHDP Referral (PM 357)

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#### INSTRUCTIONS FOR COMPLETING PART A

#### ITEM

- 1–4 Self-explanatory.
  - 5 Check the box if no services are requested but the client wants additional information about the program.
  - 6 Check yes or no as appropriate.
- 7–8 If item 6 is checked no, skip these items. If item 6 is checked yes, check the boxes in both items 7 and 8 indicating the response to the offer of transportation and scheduling assistance.
  - 9 Check yes or no as appropriate.
- 10–11 If item 9 is checked no, skip these items. If item 9 is checked yes, check the boxes in both items 10 and 11 indicating the response to the offer of transportation and scheduling assistance.
- 12–13 When the referral is being made by a CalWORKS, Medi–Cal, or placement worker, check item 12 if the request for services is from a new application or restoration or item 13 if the request is made at the annual redetermination.
  - When services have been requested directly from the local EPSDT Unit or CHDP Program, check item 14.
- 15-17 Check the one applicable box.
  - 18 Check the box when a Medi-Cal only beneficiary has to pay a share of the costs.
- 19–20 Complete if applicable. Indicate special communications needs such as deaf, blind, or illiterate—for other circumstances, item 20.
- 21–28 Fill in the state person number: (Example: 01-father, 02-mother, 11-child, etc.), and the name of the health care plan, if applicable. A person number need not be entered on self-referrals. The unshaded portion must be completed in full by the county welfare department, local EPSDT Unit, or CHDP Program staff for self-referrals, or may be completed by the client.
- 29-32 Record the caretaker's address and telephone number.
- 33-34 Optional—not required. Enter the name of the doctor or dentist who currently provides care the eligible children.

Comments: Use this section to record any comments which will help recipients receive requested services, such as the best time for them to be contacted.

- 35-37 Self-explanatory.
  - "Date eligibility determined"—Enter the date the application is determined eligible, not the date the application was made. For redetermination, the date eligibility determined is the date that the county verifies and certifies that eligibility continues. For "self-referrals" the date of request for services should be entered.

12.1204.35.a

PM 357 (6/99) Required Form

## CHDP Referral for SAWS Automated Template

# SOME COUNTY DEPARTMENT OF SOCIAL SERVICES 760 Madison Avenue P.O. Box 4650 Anywhere, CA 95973

	P.O. Box 4650 nywhere, CA 95973	
SAWS CB	DP REFERRAL	
CASE IN	FORMATION	Date:
CASE LAST NAME FIRST M	APP CO AID CODE	CASE NUMBER
RESIDENCE ADDRESS	29 84 HOME TELEPHONE MESSAGE PHONE:	
MAILING ADDRESS:		
CASE STATUS PRIMARY LANGUAGE		
DATE ELIGIBILITY DETERMINED:		
□ CALWORKS □ FOSTER CARE	DETERMINATION    MEDI-CAL ONLY	□ SELF-REFERRAL □ SHARE OF COST
□ CALWORKS □ FOSTER CARE  OTHER CIRCUMSTANCES:		
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# CHDP Referral for Welfare Case Data System Counties

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# PM 160 - Confidential Screening/Billing Report State of California—Health and Human Services Agency Department of Health Services

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RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:
The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.
Chief, Children's Medical Services Branch Primary Care and Family Health Division Department of Health Services P.O. Box 942732 Sacramento, CA 94234-7320

Section 4 Page 10

PM 160 (7/03)

(916) 327-1400

# PM 161 – Confidential Referral/Follow Up Report

Online Version: <a href="http://www.dhs.ca.gov/publications/forms/pdf/pm161.pdf">http://www.dhs.ca.gov/publications/forms/pdf/pm161.pdf</a>

State of California—Health and Human Services Agency				Chi	ld Health	and Disal	tment of bility Pre	vention Prog
CHDP CC	NFIDENTIAL REFER	RRAL/FOLLOV	V-UP REI	PORT				
CHDP Health Assessment Provider:	Diagnosis/Treatm							
<ul> <li>Retain original form in patient's medical recor</li> <li>Send photocopy to diagnosis/treatment provides</li> </ul>		n form. Retain the sign is given, send photoco					е СНГ	)P Health
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CHDP HEALTH ASSESSMENT PROVIDE								
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Responsible person (Name)	(Street)		(City)			(2	ZIP cod	ie)
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(Diagnosis/Treatment Provider)						AL 1800 1	9	
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#### RELEASE OF INFORMATION DISCLOSURE

To the responsible person:

When your child or you are referred for diagnosis and/or treatment as a result of a CHDP health assessment, this form will be used to assist in the referral. Certain information regarding the reason for referral will be written on this form.

The original will be kept in your child's or your confidential patient file by the CHDP health assessment provider, and a copy will be sent to the health care provider or agency providing diagnostic and/or treatment services.

The results of the diagnostic and/or treatment services will be recorded on the copy. It will be kept by the diagnostic and/or treatment provider in your child's or your confidential patient file. With your permission, copies will be distributed as follows:

- A copy will be sent to your local CHDP program to let them know that your child or you received the
  recommended services. The director or the deputy director of the local CHDP program at your local
  health department has the responsibility to maintain this copy as a confidential record.
- A copy will be sent to the CHDP health assessment provider to let this provider know that your child or
  you received the recommended services. This copy will be kept by the health assessment provider in
  your child's or your confidential patient file.

PM 161 (4/03) Page 2 of 2

#### **PM 160 Sample Forms and Instructions**

For PM 160 sample forms and instructions, see also the CHDP Provider Manual at the link below.

<u>http://files.medi-</u>cal.ca.gov/pubsdoco/Pubsframe.asp?hURL=/pubsdoco/CHDP\_search.asp

Click on CHPD Provider Manual > scroll down to Confidential Screening Billing Report (PM160) > click on appropriate link

#### **CHDP Forms and Publications**

The following link provides a list of the brochures, flyers/forms/manuals and reports available.

http://www.dhs.ca.gov/pcfh/cms/chdp/publications.htm#forms